SURVEY GUIDE

LONG TERM CARE FACILITIES

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
Bureau of Quality Assurance

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NURSING HOME SURVEY GUIDE

The Bureau of Quality Assurance (BQA) conducts unannounced surveys in Wisconsin nursing homes to ensure that each home meets the necessary requirements for state licensure and, if applicable, for federal Medicare and/or Medicaid certification. Surveys are outcome-oriented with a focus on current conditions at the facility. This does not mean that harm must occur in order to issue a citation or that process regulations will not be cited if resident outcome has not occurred.

The following information is intended to guide staff of Wisconsin nursing homes through the survey process.

This guide is a general reference for informational purposes. In the event of any conflict between information provided in this guide and the applicable legal requirements for nursing homes, a nursing home should rely on the applicable legal requirements.

I. OVERVIEW OF THE SURVEY PROCESS

A, OVERVIEW

The survey team includes a registered nurse, a health services specialist, and an engineer. A dietitian or pharmacist may participate on selected surveys. Surveyors evaluate nursing home performance and compliance with applicable laws and standards in the areas of:

- Resident rights
- Admission, transfer and discharge rights
- Resident behavior and facility practices
- Quality of life, including activities and resident dignity
- Resident assessment
- Quality of care
- Nursing services
- Dietary services
- Physician services
- Rehabilitative services
- Dental services
- Pharmacy services
- Infection control
- Physical environment, including sanitation
- Administration, including quality assessment and assurance

Surveyors determine compliance by observing care, interviewing residents, family members, staff and others, and reviewing medical and facility records.

B. SURVEY TASKS

The standard survey consists of the following tasks:

1. **Off-Site Survey Preparation**

   In preparing for a survey, the survey team:

   (a) Reviews files and data reports, including quality indicators, to determine resident characteristics, the make-up of the facility's population, and areas where the residents' characteristics are significantly different than those of other nursing home residents in the state;

   (b) Reviews past deficiencies to determine the regulatory areas in which they fell and to identify the residents involved in those deficiencies;

   (c) Reviews reports to identify personnel changes that have occurred since the last survey; and

   (d) Contacts the Ombudsman's office for additional information relating to the facility.

These reviews are done to identify potential areas of concern and to identify residents who possibly should be included in the sample of residents reviewed.

2. **Entrance Conference and On-Site Preparatory Activities**

Upon arrival at the facility, the survey coordinator introduces the members of the survey team, describes the survey process, shares quality indicator reports, and identifies the forms the facility must complete. These forms include the Roster/Sample Matrix form, which must be completed within one hour of the team's arrival, and the Resident Census (CMS-672) form, which must be completed and given to the coordinator within 24 hours of the team's arrival. (BQA will make exceptions to these time frames when the survey begins on the weekend or during off-hours.) The survey coordinator informs the administrator that surveyors may ask staff to accompany them during the survey and that surveyors may be taking pictures of residents or of the environment as a means of preserving evidence.

The facility may wish to designate a primary contact to work with the BQA team coordinator as a point of contact and reference.

3. **Facility Tour**

The facility tour occurs simultaneously with the entrance conference and involves the remaining members of the survey team. The tour allows the survey team to meet residents and to begin a Quality of Life and Environmental Quality review. The survey team usually completes the tour within two hours after arrival, depending upon the size of the facility. BQA encourages facility staff to share information about residents with surveyors during the tour.

4. **Resident Sampling**

Shortly after the tour, the survey team selects the residents to be included in the resident sampling process. The survey team bases the number of residents selected for review on the facility's census at the time of survey. Sampling occurs in two stages. In the first stage, the survey team selects 60% of its sample based upon concerns identified during off-site preparation and the initial tour. The remaining 40% of sample residents are selected in the second stage of sampling, based on concerns that were identified or left unresolved during the first stage. At least half of the sample residents will be residents with pressure sores, weight loss, or dehydration if quality indicators suggest potential problems in these areas.

The survey team must select at least one resident from each of the following four categories:

- Interviewable, light-care residents
- Interviewable, heavy-care residents
- Non-interviewable, light-care residents
- Non-interviewable, heavy-care residents

5. **Information Gathering**

The survey team obtains information during the survey in various ways. Several tasks completed by the survey team are listed below.

A. **General Observations of the Facility**

The survey team makes general observations of the facility's environment and the extent to which the rights of residents are promoted and respected.

B. **Kitchen/Food Service Observations**

Surveyors assess facility performance in preventing food-borne illness by observing food storage, food preparation, and food service.

C. **Resident Review**

During the resident review, the survey team assesses:

Resident Rooms - to determine environmental quality and the degree to which each room meets the needs of the residents living in the room;

Daily Life Activities - to determine how staff interact with residents, to determine the extent to which staff accommodate resident needs and allow choices in daily decisions, and to determine the appropriateness and adequacy of activities, as determined by each resident's interests and needs;

Drug Therapies - to determine whether unnecessary drugs are being given, to determine if side effects have developed, and to determine if the facility is appropriately monitoring drugs; and

Quality of Care - to determine the accuracy of resident assessments in identifying resident needs; to assess the degree to which care plans have been developed and implemented; and to determine whether residents' conditions have declined or failed to improve and to determine whether these changes were avoidable or unavoidable. The survey team may take photos of residents, such as bruises or pressure ulcers. Generally, this is done with the resident's or legal decision maker's permission,

D. **Quality of Life Assessment.**
The survey team, through interviews and observations, determines the extent to which the facility promotes resident dignity, individuality, and choice and enables residents to achieve and maintain their highest level of functioning and psychosocial well being.

E. **Medication Pass**
The survey team watches the administration of at least 20-25 medications to evaluate the accuracy of medication administration.

F. **Quality Assessment and Assurance (Q.A.A.) Review**
The survey team determines whether the facility has a functioning Q.A.A. committee that is identifying and responding to problems, communicating changes in policies and procedures to staff, and evaluating responses to cited deficiencies. The survey team does not use the minutes of a facility's Q.A.A. committee to identify deficiencies but may interview staff to determine compliance status.

G. **Protocols for Preventing Abuse, Neglect and Misappropriation of Resident Property**
The survey team will review facility records and speak with staff, residents, and family members to evaluate the facility's system for preventing resident abuse, neglect and mistreatment, and misappropriation of resident property.

6. **Information Analysis/Decision Making**
Throughout the survey, the survey team reviews and analyzes all information to determine whether the facility has complied with all applicable federal and state requirements. Decision-making is an ongoing process that continues after the survey is completed.

A **deficiency** exists when a facility fails to comply with a federal regulation. A **violation** exists when a facility fails to comply with a state statute or administrative rule. All citations are written on the CMS-2567 Statement of Deficiencies (SOD) or the CMS "A" form.

Certified nursing homes must meet *resident-centered* federal regulations for each resident. These are regulations that refer to <u>each</u> resident or <u>the</u> resident. Regardless of severity, one example of noncompliance with a resident-centered federal regulation shows that a deficient practice exists. Examples of such regulations are:

"The resident has the right to be free from any physical or chemical restraints…" [F221, 42 CFR 483.12(a)], and

"The facility must provide for an ongoing program of activities designed to meet...the physical, mental, and psychosocial well-being of each resident." [F248, 42 CFR 483.15(f)(1)]

Facility-centered federal regulations refer to systems or processes that facilities must have in place. One example of noncompliance with a *facility-centered* federal regulation does not necessarily mean a deficiency exists. Citations of facility-centered regulations are based on evidence that a system or process was not functioning. For example, one example of a non-sterile dressing change would not necessarily mean that the facility had failed to comply with the requirement at F441 [42 CFR 483.65] to "maintain an infection control program…."

In certain cases, a deficient practice may lead to noncompliance with more than one regulation. When determining potential citations, BQA will look at the applicable outcome regulations and the process regulations that may have led to the outcome or potential outcome. The Centers for Medicare and Medicaid Services (CMS) has instructed states to look at and to cite all independent but associated regulations for which noncompliance exists.

A decision to cite a state law or state administrative rule violation (e.g., HFS 132) is made on the basis of the probability and seriousness of harm that the violation creates. Actual harm to a resident need not occur. Generally, BQA will not cite violations of state regulations unless the violation is at the level of a class A (substantial probability for death or serious harm) or a class B (direct threat to resident health, safety, and welfare). BQA will also cite state code violations, regardless of their level of classification, if there is no corresponding federal regulation, if a federal regulation is being re-cited, or if there is a compelling need to establish a track record of state code violations.

7. **Exit Conference**

Although not required, the survey coordinator, as a courtesy to facilities, will usually meet with facility administration at the end of the day to alert administration of its findings and the areas in which deficient practices exist. The survey team will not discuss concerns that do not immediately jeopardize residents if the team is still gathering information to determine whether a violation exists or is still gathering information to establish the extent of the problem. When the team brings concerns to the facility's attention, we encourage the facility to provide any documentation or other information that might clarify or modify the team's perception of the situation.

When the survey team has concluded its on-site survey, the team coordinator conducts an exit conference with the facility administrator or designee. The administrator can determine which staff, board members, etc. may attend the exit conference. Administrative staff should encourage residents to attend and should make necessary accommodations so residents can attend. During the exit conference, the coordinator summarizes the team's conclusions and, when applicable, presents the findings that substantiate noncompliance. Providers are encouraged to use the exit conference to supply additional information that may clarify or refute findings. Because of the ongoing dialog that has occurred, there should be few instances where the facility is not aware of surveyors' concerns prior to the exit conference. Typically, the only "surprises" at the exit conference should be those situations that have just occurred or situations where the survey team has needed ongoing monitoring to determine if a deficient practice exists or to determine scope or severity.

The exit conference for the Life Safety Code survey may or may not be held with the health surveyors, depending upon the timing of the Life Safety Code survey.

The facility may have an attorney present but we request that you give advance notice of this to the survey coordinator. A court reporter may not attend the exit. If a facility makes an audio or video tape recording of the exit, the facility must make a simultaneous recording and give it to the survey team.

When deficiencies or violations are found, BQA, in most cases, will mail the Statement of Deficiencies to the facility or the chapter 50 designee within ten working days of completion of the health survey. Similarly, in most cases, BQA also will mail the SOD with Life Safety Code deficiencies to the facility or the chapter 50 designee within ten working days of completion of the Life Safety Code survey. During the period of time in which the Statement of Deficiencies is being written and reviewed, the nursing home may submit additional information to the regional office that will refute the decision that had been made to cite or that will modify scope or severity.

Occasionally, during the period in which the Statement of Deficiencies is being written and reviewed, supervisory and Quality Assurance review of the findings may lead to dropping a citation, citing a deficiency that had not been discussed with the facility at the survey or to changing the level of scope and severity. If this occurs, BQA staff will notify the facility by phone. This gives the facility an opportunity to respond before BQA writes and mails the Statement of Deficiencies.

II. EXPLANATION OF CITATIONS

Federal deficiencies are cited separately from state violations. BQA assigns a federal severity/scope category to each federal citation and a state classification to each state citation. These are explained on the following pages.

A. **Classification of Violations of Chapter HFS 132, Wis. Administrative Code or Chapter 50, Wis. Stats.**

All state-code violations are classified according to their level of severity and according to the probability for harm occurring.

1. *Class "A"*: This is a violation that creates a condition or occurrence relating to the operation and maintenance of a nursing home which presents a substantial probability for resident death or serious mental or physical harm. A facility must immediately correct a Class "A" violation unless BQA sets a fixed period of time while reviewing the plan of correction. BQA may assess forfeitures of up to $10,000 per day of violation. (Sec. 50.04(5)(a)1, Wis. Stats.) [For computer purposes only, class A violations show a scope/severity rating of "F" in the left-hand column of the Statement of Deficiencies.]

2. *Class "B":* This is a violation that creates a condition or occurrence relating to the operation and maintenance of a nursing home which directly threatens the health, safety or welfare of a resident. Class B violations are subject to a forfeiture of up to $5,000 per day of violation. (Sec. 50.04(5)(a)2, Wis. Stats.) [For computer purposes only, class B violations show a scope/severity rating of "B" in the left-hand column of the Statement of Deficiencies.]

   For computer purposes only, a state code violation that has example(s) at the level of a class A and example(s) at the level of a class B will have a scope/severity rating of "G" in the left-hand column of the Statement of Deficiencies.3.

3. *Class "C" level:* This is a violation that creates a condition or occurrence relating to the operation and maintenance of a nursing home which does not directly threaten the health, safety or welfare of a resident. A Class C level violation may be issued as a:

   Class C, when the licensee violated the same statute or rule during the previous 2 years or when a nursing home fails to correct a correction order by the date specified. Class C violations are subject to a forfeiture of up to $500 per day of violation. (Sec. 50.04(5)(a)3, Wis. Stats.) [For computer purposes only, class C violations show a scope/severity rating of "C" in the left-hand column of the Statement of Deficiencies.]

   Correction order, when the licensee has not violated the same state statute or administrative rule in the previous two years. [For computer purposes only, corrections orders show a scope/severity rating of "D" in the left-hand column of the Statement of Deficiencies.]

   Notation, when the licensee did not violate the same state statute or administrative rule in the previous two years and is able to correct the violation by the end of the onsite survey. [For computer purposes only, notations show a scope/severity rating of "E" in the left-hand column of the Statement of Deficiencies.]

B. **Federal Deficiencies**

Each federal deficiency is categorized by severity and scope, using the following guidelines:

Severity/Harm (resident outcome)

Harm level 4. (Immediate jeopardy.) Immediate jeopardy exists when a deficient practice has caused or is likely to cause serious injury, serious harm, impairment or death to a resident receiving care in the facility. Immediate corrective action is or was needed at the time of the deficient practice to prevent death or serious harm from occurring. Immediate jeopardy is not removed as long as facility practice establishes a reasonable degree of predictability of similar actions, situations, practices or incidents occurring in the future.

Harm level 3. Harm at level 3 exists when a deficient practice causes a negative outcome that compromises the resident's ability to maintain and/or reach his or her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

Harm level 2. Harm at level 2 exists when a deficient practice causes minimal physical, mental and/or psychosocial harm (discomfort) to the resident. Harm at level 2 also exists when a deficient practice has the potential to compromise the resident's ability to maintain and/or reach his or her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

Harm level 1. Harm at level 1 exists when a situation has the potential for causing no more than minor negative impact on residents.

If a federal deficiency has multiple examples at different harm levels, the most serious harm level determines the category, along with the frequency associated with that particular harm level.

Frequency (or scope) is classified as follows:

Isolated (Scope 1). If a situation affects or involves a very limited number of residents and/or one or a very limited number of staff, and/or the situation occurs only occasionally or in a very limited number of locations, then the deficiency is classified as "isolated."

Pattern (Scope 2). If a situation involves or affects more than a very limited number of residents, and/or involves more than a limited number of staff, and/or the situation occurs in several locations, then the deficiency is classified as "pattern." A "pattern" also exists if a deficient practice is widespread within a small subset of all residents in the facility (e.g., residents with gastrostomy tubes).

Widespread (Scope 3). If a situation is pervasive throughout the facility or represents a systemic failure that affects or has the potential to affect a large portion of the facility's residents, then the deficiency is classified as "widespread."

Past Noncompliance. A federal deficiency will not be issued for deficient practices that occurred prior to the survey, if the following conditions are met:

1. The facility was in compliance with all other federal regulations at the time the deficient practice occurred (i.e., did not have any outstanding deficiencies that had not yet been verified as corrected).
2. The facility identified the deficient practice at the time it occurred.
3. The facility took appropriate measures to correct the deficient practice and to prevent it from reoccurring.
4. The deficient practice has not reoccurred and the facility is currently in compliance with the regulation.
5. The deficient practice was at a scope/severity level of G (actual harm/isolated) or below. (In certain cases, past noncompliance at a scope/severity level of G may be cited.)

III. EXTENDED/PARTIAL EXTENDED SURVEYS

A. **Extended Survey**

BQA will conduct an extended survey within two weeks of completion of the standard survey whenever a facility has **substandard quality of care**, i.e., any deficiency in one of the following groups of federal regulations
42 CFR 483.13 Resident Behavior and Facility Practices,
42 CFR 483.15 Quality of Life, or
42 CFR 483.25 Quality of Care

that has a scope/severity level of:

- immediate jeopardy (harm level 4)
- harm level 3 that is a pattern or widespread, or
- harm level 2 that is widespread.

During an extended survey, surveyors add to the sample of resident reviews, review policies and procedures pertinent to the areas of deficiencies, and review staffing, inservice training, and contracts with consultants, if appropriate.

B. **Partial Extended Survey**

BQA conducts a partial extended survey within two weeks of completion of an abbreviated survey (e.g., complaint or revisit) after identifying substandard quality of care. Depending upon its findings during a partial extended survey, the survey team may expand the scope of its review to include a more comprehensive evaluation of compliance with the requirements under which substandard quality of care was found.

C. **Loss of Nurse Aide Training and Competency Evaluation Program (NATCEP)**

Facilities that are subject to an extended or partial extended survey because of the finding of substandard quality of care are prohibited from offering or conducting a Nurse Aide Training and Competency Evaluation Program for a two-year period. This prohibition cannot be appealed. Facilities can request and may be granted a waiver of this prohibition if certain criteria are met.

IV. PLANS OF CORRECTION (POC)

A. **Requirements for Submitting a Plan of Correction**

Nursing homes must submit a plan of correction (POC) for:

- All state violations, except correction orders and notations; and
- All federal deficiencies that are not at harm level 1/isolated.

Nursing homes must complete and mail plans of correction to the appropriate BQA regional office by the 10th calendar day following receipt of the Statement of Deficiencies.

For state violations, BQA may extend the time frame for submitting plans of correction up to 30 calendar days if the plans involve substantial capital improvements. A facility must submit a written request for an extension to the Provider Regulation and Quality Improvement Section of BQA prior to the 10th day following receipt of the Statement of Deficiencies to obtain the extension. BQA will send written notice of approval or denial of the extension to the facility.

B. **Content of the Plan of Correction**

The plan of correction must:

- Identify WHAT measures will be implemented for those residents found to have been affected by the deficient practice.

- Identify HOW the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.
- Identify WHAT measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur.
- Identify HOW the facility will monitor its performance to ensure that the deficient practice is corrected and does not reoccur (e.g., monitoring by its quality assessment and assurance committee).
- Identify a date by which substantial compliance will be achieved. In most cases, BQA expects facilities to be in substantial compliance within 30-45 days following the survey exit.

A representative of the nursing home must sign and date plans of correction.

The plan of correction must describe the corrective action the facility will take to address the cited violation or deficiency, as described above. Although a facility may include in its plan of correction a statement that it disagrees with the survey findings, a facility may not use the plan of correction to malign the survey team or an individual surveyor.

BQA will not approve a plan of correction that does not meet these standards. In such a case, BQA will identify why the plan of correction was not acceptable, return it, and request that an acceptable plan be submitted within 5 calendar days. A facility that fails to submit an acceptable plan of correction is subject to the actions described in subsection D, below.

If you have questions while drafting plans of correction, you may contact the surveyor or the Regional Field Operations Director or Supervisor.

C. **Report of Correction**

A facility that corrects a state violation prior to submitting a plan of correction may submit a notarized statement attesting to correction in lieu of submitting a plan of correction.

D. **Failure to Submit an Acceptable Plan of Correction**

If a nursing home that participates in the Medicare or Medicaid program fails to submit a timely plan of correction (POC), BQA may immediately implement alternative federal enforcement remedies or initiate action to terminate the facility from the program. BQA may impose a plan of correction if a facility fails to submit an acceptable POC.

E. **Extended Time Period for Correction**

A facility that cannot correct a **state** violation by the established completion date may request an extension by writing the regional office at least five calendar days prior to the correction date. BQA will determine whether the extended correction time is reasonable and will notify the facility of its decision.

F. **Verification of Correction**

BQA will verify correction of all state violations and federal deficiencies after the established completion dates have passed. Verification of correction may be done through an onsite revisit or through a desk review of the plan(s) of correction depending upon the nature of the citations, the regulatory groupings in which fell, and their scope/severity level.

G. **Failure to Correct State Violations or to Achieve Substantial Compliance with Federal Deficiencies**

STATE VIOLATIONS: Failure to correct a state violation by the date specified in the plan of correction may result in one or more of the following :

1. A forfeiture, or an increased forfeiture, on state class A, B and C violations.
2. Suspension or revocation of the facility's license or issuance of a conditional license.
3. Injunction for uncorrected class A violations.

4. Appointment of a state monitor or receiver, if the Department determines that the facility cannot protect the health, safety and welfare of residents.
5. Suspension of admissions if a class A or class B violation is not corrected within 90 days after receiving the violation. This applies to nursing homes that received one class A or three class B violations in the previous 12 months and also received one class A or three class B violations in a 12-month period during the 3 years preceding the first 12-month period.

FEDERAL DEFICIENCIES: Failure to achieve substantial compliance with federal requirements may result in the following adverse actions:

1. For facilities with an opportunity to correct, a recommendation to CMS or the State Medicaid Agency to proceed with implementation of federal enforcement remedies. These remedies are associated with the deficiency having the highest scope and severity at the revisit.
2. For facilities without an opportunity to correct (where enforcement remedies were implemented immediately following the survey), a continuation or modification of the remedy already implemented.
3. Denial of payment for new admissions if the facility is not in substantial compliance with all federal nursing home regulations within three months from the survey exit date.
4. Termination of the federal provider agreement for facilities participating in Medicare or Medicaid if the facility is not in substantial compliance within 180 days from the survey exit date. Termination of the federal provider agreement may also occur if a facility does not remove an immediate jeopardy situation within 23 days from the date the SOD is issued.

V. INFORMAL DISPUTE RESOLUTION

Facilities that disagree with all or part of a federal or state SOD may request informal dispute resolution (IDR), with two exceptions:

- ►IDR does not apply to a re-cited citation where (a) the re-cited facts are identical to the facts on the original citation; and (b) the original citation has already gone through IDR.

- ►IDR cannot, in general, be used solely to challenge the scope and severity assigned to a particular citation without challenging underlying facts and examples.

The Michigan Peer Review Organization (MPRO), through contract with BQA, conducts all nursing home informal dispute resolution cases.

The procedures and timelines for requesting informal dispute resolution are posted to the Web and may be found at: **http://dhfs.wisconsin.gov/rl_DSL/Publications/pdfmemos/06-005.pdf**

Case Conference
Pursuant to sec. 50.053, Wis. Stats., a facility may request an informal case conference to discuss and attempt to resolve, prior to hearing, any contested action initiated under subchapter I of chapter 50, Wis. Stats. (e.g., state violations and forfeitures). However, in order to preserve your rights to a hearing, an appeal must be filed within ten days of receipt of your SOD or forfeiture invoice. Scheduling IDR or a case conference does not constitute an appeal of the department action. (See below)

VI. APPEALS

In addition to requesting informal dispute resolution, a facility may appeal certain Department actions related to federal or state citations.

A. Appeals of State Violations, Imposed Plans of Correction, Forfeitures, and Suspension of Admissions

If a facility desires to contest the issuance of state Class A, B, or C violations, notations, plans of correction imposed on state violations, state forfeitures or suspensions of admissions, it must send a written request for a hearing within 10 days of receipt of the SOD or other department action, with a description of the action being contested, to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison WI 53705-5400

A nursing home must submit its appeal within 10 calendar days of receipt of notice of the Department action. The appeal must include a concise statement of the reason for objecting to the action.

Every state class A, class B, and class C violation is reviewed to determine the appropriateness of a forfeiture or other state enforcement action. This review is conducted after IDR is completed. If the facility feels that there are extenuating circumstances or that they have information that would mitigate the circumstances of the violation as written, additional information can be sent to:

Bureau of Quality Assurance
Provider Regulation and Quality Improvement Section
P. O. Box 2969
Madison, WI 53701-2969

The additional information could include post-survey information including, but not limited to:
- Systems changes
- Cost of enhancements to systems to assure maintaining compliance
- New programs
- Possible hiring of consultants
- Purchase of equipment

A facility that does not appeal a state violation and the forfeiture assessed on the violation will receive an automatic 35% reduction of the forfeiture if the forfeiture is paid within 10 days after receipt of the assessment notice.

B. Appeals of Federal Deficiencies that Result in the Imposition of a Remedy

A facility may appeal a certification of noncompliance leading to an enforcement remedy [42 CFR 488.408(g)(1)] within 60 calendar days of receipt of the notice that imposes a federal remedy. Enforcement remedies may include civil money penalties, denial of payment for new admissions, temporary manager, a directed plan of correction, or directed inservice training. A facility may **not** appeal the choice of remedy [42 CFR 488.408(g)(2)]. Medicare certified facilities (SNFs) and dually certified facilities (SNFs/NFs) should mail their appeals to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
ATTN: Oliver Potts, Chief
Cohen Building, Room G-644
330 Independence Ave. SW
Washington, D.C. 20201

Facilities are asked to send a copy of their request to:

Center for Medicare and Medicaid Services
ATTN: Sabrina Stinson

233 N. Michigan Ave., Suite 600
Chicago, IL 60601-5519

Medicaid-only facilities (NFs) should mail their appeals to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison WI 53705-5400

C. **Medicaid Termination and Informal Reconsideration**

Medicaid-only facilities wishing to contest the termination of Medicaid certification must send a written request, including a copy of the notice of the action being contested, to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison WI 53705-5400

A facility must submit its request for a hearing on termination or non-renewal of Medicaid certification within 60 calendar days after receiving notice of the action.

In addition to filing an appeal, a Medicaid-certified facility also may request an informal reconsideration conference. To do so, it must submit a written request for informal reconsideration. The request may include any information that refutes the findings on which the termination is based. The request must be postmarked within 10 calendar days of receipt of a termination notice and be submitted to:

Administrator
Division of Disability and Elder Services
P.O. Box 7851
Madison, WI 53707-7851

D. **Medicare Termination**

To appeal Medicare termination, Medicare-certified facilities (SNFs) and dually certified facilities (SNF/NFs) must request a hearing before an administrative law judge of the Office of Hearings and Appeals, Social Security Administration. The facility must file an appeal within 60 calendar days of receipt of notice of the termination decision from the Centers for Medicare and Medicaid Services (CMS). [42 CFR 498.40(a)(1) & (2), 42 CFR 431.153(g)]

(Pursuant to 42 CFR 498.22(b)(3), the date of receipt is presumed to be five days after the date on the notice, unless evidence shows that it was, in fact, received earlier or later.) This appeal should be mailed to either:

Elizabeth Honiotes
Branch Manager
Indiana/Wisconsin Long Term Care Branch
Centers for Medicare and Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Department Appeals Board
Civil Remedies Division
Attn: Oliver Potts, Chief
Room 637- D, HHH Building
200 Independence Ave. S.W.
Washington D.C. 20201

Dually certified facilities must file any appeal of termination with the Centers for Medicare and Medicaid Services.

E. **License Revocation, Suspension, or Denial of a Regular License**

A facility must submit its request for hearing on the revocation or suspension of a license or the denial of a regular license within 10 calendar days of receipt of the notice of the Department's action. The request must be submitted to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison WI 53705-5400

F. **Denial of State Waiver or Variance Request**

A facility may appeal the denial of a request for a state waiver or variance by writing to:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison WI 53705-5400

The facility has the burden of proving that the denial of a waiver or variance was unreasonable.

G. **Care Level Determinations**

A resident may appeal a care level determination within 45 calendar days of the date of the notice. The appeal must be filed with:

Division of Hearings and Appeals
5005 University Avenue, Suite 201
Madison WI 53705-5400

An administrative law judge will hold a hearing within 90 calendar days from the date of the request for a hearing. [42 CFR 431.244(f)] Reimbursement for care and services will continue pending the decision for residents who appeal a change in the care level determination prior to the effective date of the care level change. The Department may recoup the cost of excess payments made on the resident's behalf if the Department's care level determination is upheld. [42 CFR 431.230(b)]

VII. WAIVERS AND VARIANCES

BQA may grant state waivers or variances for violations of state codes. All waivers and variances are reviewed annually.

A. **State Code Waiver or Variance**

A "waiver" grants an exemption from a requirement of ch. HFS 132, Wisconsin Adm. Code.

A "variance" grants an alternate requirement in lieu of a requirement of ch. HFS 132, Wisconsin Administrative Code.

1. **Submitting a Waiver or Variance Request**

a. Waiver or variance requests may be submitted at any time by writing to BQA's Chief of the Provider Regulation and Quality Improvement Section. The request must include:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- The reason for the request.
- The alternative actions proposed if a variance is requested, or the specific residents or rooms affected if a variance or waiver is requested.
- Documentation of assurance that resident health, safety or welfare will not be adversely affected.
- Why compliance with the rule would result in unreasonable hardship; or why the proposed alternative to the rule is in the interests of better care or management.

b. The Department will grant or deny a request, in writing, within 60 calendar days of receipt of a complete request. Notice of denials shall contain the reason for denial. If BQA does not issue a notice of denial within 60 calendar days, the waiver or variance is automatically granted.

c. The Department may, in consultation with the facility, modify the terms of the waiver or variance, impose conditions on the waiver or variance, or limit the duration of any waiver or variance.

d. A facility may appeal the denial of a state waiver or variance as noted in section VI. F.

2. **Revoking a Waiver or Variance**

The Department may revoke a waiver or variance if:

a. It determines that continuance of the waiver or variance adversely affects the health, safety or welfare of a resident;

b. The facility fails to comply with the conditions imposed on the waiver or variance;

c. Revocation is required by a change in law; or

d. The licensee notifies the Department in writing that it wishes to relinquish the waiver or variance.

3. **Approval for Admission of a Minor**

A facility may not admit a person under the age of 18 unless the Department approves the admission. A facility must follow the process outlined in sec. HFS 132.51(2)(f) to request approval to admit an individual under the age of 18. A facility should send a request in writing with:

a. A statement from the referring physician stating the medical, nursing, rehabilitation, and special services required by the minor;

b. A statement from the administrator certifying that the required services can be provided;

c. A statement from the attending physician certifying that the physician will be providing medical care; and

d. A statement from the persons or agencies assuming financial responsibility.

A facility may mail or FAX this information to the BQA's Provider Regulation and Quality Improvement Section. The mailing address is Provider Regulation and Quality Improvement Section, PO Box 2969, Madison, WI 53701-2969. The FAX number is (608) 267-7119.

B. **Federal Regulation Waivers**

1. Waivers of federal regulations may be granted only for:
   - Life Safety Code: 42 CFR 483.70(a),
   - Nurse staffing: 42 CFR 483.30(c) and (d), or
   - Residents' room sizes: 42 CFR 483.70(d)

   A facility must send each federal waiver request to BQA's Chief of the Provider Regulation and Quality Improvement Section, PO Box 2969, Madison, WI 53701-2969 or include it as part of a plan of correction. The BQA will forward certain federal waiver requests to the Centers for Medicare and Medicaid Services (CMS).

2. The Center for Medicare and Medicaid Services will grant a federal waiver only if:
   - A facility demonstrates that approval of the waiver will not adversely affect resident health, safety or welfare; or
   - Denial of a Life Safety Code waiver request creates an unreasonable hardship.

3. Facilities that have lost approval to offer or to conduct a Nurse Aide Training and Competency Evaluation Program may request a waiver by writing to the Office of Caregiver Quality, 2917 International Lane, Suite 300, Madison, WI 53704.

VIII. CONCLUSION

The Bureau of Quality Assurance is committed to fair, consistent, and professional enforcement of state and federal requirements. If you have a concern, please write to:

Director
Bureau of Quality Assurance
PO Box 2969
Madison, Wisconsin 53701-2969

Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Quality Assurance
List of Addresses, phone numbers and FAX numbers

Madison/Southern Regional Office
Bureau of Quality Assurance
2917 International Lane, Suite 210
Madison WI 53704
Reg. Field Operations Director (608) 243-2374
Office FAX No. (608) 243-2389
E-mail: virnipe@dhfs.state.wi.us

Milwaukee/Southeastern Regional Office
Bureau of Quality Assurance
819 N. 6th Street, Room 609B
Milwaukee WI 53203-1606
Reg. Field Operations Director (414) 227-4908
Office FAX No. (414) 227-4139
E-mail: frienka@dhfs.state.wi.us

Green Bay/Northeastern Regional Office
Bureau of Quality Assurance
200 N. Jefferson Street, Suite 211
Green Bay WI 54301
Reg. Field Operations Director (414) 448-5249
Office FAX No. (414) 448-5254
E-mail: poweljm@dhfs.state.wi.us

Eau Claire/Western Regional Office
Bureau of Quality Assurance
610 Gibson Street- Suite 1
Eau Claire WI 54701-3687
Regional Field Operations Director (715) 836-4753
Office FAX No. (715) 836-2535
E-mail: bronnja@dhfs.state.wi.us

Rhinelander/ Northern Regional Office
Bureau of Quality Assurance
2187 Stevens St., Suite C
Rhinelander WI 54501
Regional Field Operations Director (715) 365-2802
Office FAX No. (715) 365-2815
E-mail: poweljm@dhfs.state.wi.us

Provider Regulation and Quality Improvement Section
PO Box 2969
Madison, WI 53701-2969
Section Chief (608) 266-2055
Office FAX No. (608) 267-7119
E-mail: eakinjl@dhfs.state.wi.us

Madison/Central Office
Bureau of Quality Assurance
1 West Wilson Street, Room 1150
PO Box 2969
Madison, WI 53701-2969
Chief, Resident Care Review Section
(608) 267-7157
Office FAX No. (608) 267-0352
E-mail: pesheph@dhfs.state.wi.us

IDR Intake Coordinator - Gail Hansen
Bureau of Quality Assurance, Central Office
Provider Regulation & Quality Improvement
Phone: (608) 266-2966
Fax: (608) 267-7119